

INJURY REPORT

Name _____ Date of Birth _____ Phone _____

Address _____ City _____ State _____ Zip _____

SSN: _____ Date of Injury: _____ Time: _____ AM PM

Circle type of injury: Worker's Comp Personal Injury Auto Other

Insurance Company _____ Address _____

Agent's Name _____ Phone _____ Policy No. _____

In your own words, please describe injury (where and how it happened to you): _____

Did you have any physical complaints before the injury? Yes No

If yes, please describe in detail: _____

Please describe how you felt:

a. BEFORE the injury: _____

b. DURING the injury: _____

c. IMMEDIATELY after the injury: _____

d. LATER in the day: _____

e. NEXT day: _____

Have you lost time from work as a result of this injury? Yes No

If yes complete:

a. Last day worked: _____ Place of employment: _____

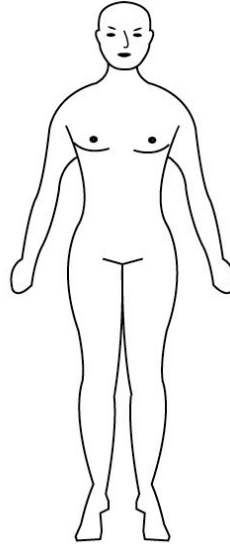
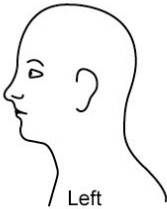
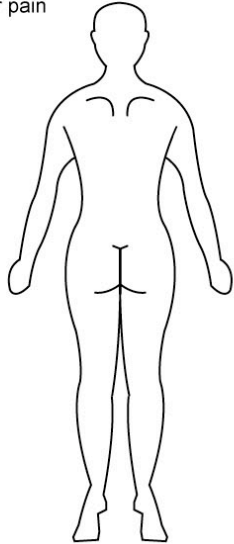
b. Type of employment: _____ Supervisor _____ Phone _____

Have you been treated by another doctor for this injury? Yes No

If yes list the doctor's name and address _____

What type of treatment did you receive? _____

Please mark your pain on the following diagrams:



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Name _____

What are your PRESENT complaints and symptoms? _____

- BACK PAIN:**
1. Currently, I have pain in my:
 lower back Middle back upper back
 2. My pain began:
 gradually suddenly
 3. I have pain:
 sometimes all of the time
 4. My pain goes into my:
 right leg left leg both
 5. I have tingling and/or numbness in my:
 right leg left leg both
 6. My pain is worse when I:
cough or sneeze Yes No
sit Yes No
bend Yes No
walk Yes No
lift Yes No
push Yes No
pull Yes No
 7. My back is worse with sexual activity Yes No
 8. My pain wakes me up during the night Yes No
 9. Changes in the weather affect my pain Yes No

- NECK PAIN**
1. My neck pain began: gradually suddenly
 2. I have pain: sometimes all of the time
 3. My pain goes into my: right arm left arm both
 4. I have tingling and/or numbness in my: right arm left arm both
 5. My pain is worse when I:
cough or sneeze Yes No
sit Yes No
bend Yes No
walk Yes No
lift Yes No
push Yes No
pull Yes No
 6. My pain wakes me up during th night Yes No
 7. Changes in the weather affect my pain Yes No
 8. I have neck stiffness Yes No
 9. I have headaches Yes No
 10. If I do get headaches, they occur: Sometimes All of the time

Signature _____ Date _____

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